Editorials

A Time to Lead, a Time to Follow

PHYSICIANS ARE A VITAL PART OF SOCIETY. We are reminded of this daily and especially when "the system" does not seem to be working well. Not long ago, I talked with a worker from a small lead battery plant. He and his family no longer had health insurance. His financially strapped employer had stopped buying the insurance and, instead, had given him a $100 a month raise. "I can't get insurance for my family and me for $100 a month. Anyway, I pay taxes on it, so it isn't even $100. When my toe got infected, I couldn't see a doctor and it was real bad, so I was out of work. The kids haven't gotten their shots. We've got no hope of seeing a dentist." Society hasn't risen to the occasion, at least for that worker.

Society has subsidized our education, whether in public or private medical schools. Society supports the research that underpins our methods, procedures, and prescriptions. Society recognizes our skills by seeking our help at crucial times. As we see the challenges all around, we know that we are among those who must respond most thoughtfully. What more can we do about improving health and access to good health care?

Ralph Crawshaw, our assistant editor for Health and Public Policy and Project Director for Oregon Health Decisions, observes that physicians should be wise civic participants, not just clinicians. Practicing our profession is not enough. Physicians need to engage in active dialogue with patients and policy makers. We need to communicate beyond the chief complaint and differential diagnosis.

We also need to agree about important elements in any new health care proposal. These elements include basic care for all; prevention of disease and disability; physician accountability; ease of access, ease of payments; integration with social, nutrition, and housing services; more emphasis on the system's function than structure; a certain tempering of patients' expectations regarding diagnosis, treatment, and cure, which could lead to decreased physician liability. In addition to meeting all of these criteria, patients and physicians must feel good about the proposed system. This satisfaction makes sharing responsibilities more of a partnership than a burden. There is, as we are all taught, a physician/patient relationship. Who is the leader? Who is the follower?

In his recent book, *On Leadership,*[1] John W. Gardner, philosopher-statesman and former Secretary of the Department of Health, Education, and Welfare, describes his and others' views on leadership. In doing so, he also focuses on "followership." He notes, "Followers do like being treated with consideration, do like to have their say, do like a chance to exercise their own initiative—and participation does increase acceptance of decisions." He describes early sociologist Georg Simmel's theories by saying, "In a sense, leadership is conferred by followers." Gardner's practical answer to a query on leadership: "The most important thing to have in mind is that leaders need followers." Finally, "In the conventional mode people want to know whether the followers believe in the leader; a more searching question is whether the leader believes in the followers."

If physicians are to help lead in designing and implementing solutions to America's health care challenges, we must listen carefully to our patients. We must recognize and work toward meeting their needs. We must have their trust. Indeed, in some respects we must be their followers.

The physician/patient relationship goes far beyond office walls. It is far grander than one to one. It extends across the country and throughout all segments of society. It is a partnership of leaders and followers who need to respect one another and to communicate well. We should do everything we can to learn from and support one another; to lead, to follow.

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REFERENCE

1. Gardner JW: On Leadership. New York, The Free Press (a division of Macmillan, Inc), 1990, pp 24-199

Women Mentors Needed in Academic Medicine

WOMEN IN MEDICINE and other fields are increasingly filling positions at the lower levels of the academic ladder, but relatively few can be found at the ranks of associate and full professor. The explanation sometimes given is that there is an insufficient number of more senior women. This explanation might have been true when the number of women entering medicine was just starting to increase. After two decades in which substantial numbers of women have entered medicine, however, it cannot account for the failure in recent years to show increases of women in tenured positions. It is difficult to explain why there has been no increase from 1985 to 1989 in the proportion of female associate professors in medical schools (20% at both times). It is even more difficult to explain why, during this time the proportion of female full professors on medical faculties actually dropped from 10% to 9%.[1]

In this issue, Levinson and colleagues point to one reason why women may have difficulty ascending the academic ladder[2]: the lack of mentors and role models. Their study does not address this lack directly. Rather, it demonstrates the contribution to achievement for women in academic medicine of having mentors and role models. If having mentors and role models facilitates achievement and if women have less access to mentors and role models than do men, it will be more difficult for women to succeed.

Several studies in addition to the one in this issue have shown the beneficial effects of mentoring on career success.[3,4] Of a sample of almost exclusively male senior faculty surveyed at one medical school, 90% reported that they had had a mentor and that this had assisted them in their career development.[3] In a sample of female lawyers, those who had a true mentor—meeting precise criteria for the types of support that a mentor gives—showed greater career success and satisfaction than did women who had no mentor. They were also more successful than the women who reported that they had had a mentor but for whom the actual mentoring activity did not meet the criteria. Moreover, the women who did not have a true mentor but pieced together support from different people were not as successful and satisfied as those who had had a single mentor.[4]

Compared with male physicians, female physicians in an academic community appear less likely to have the benefit of a mentor. In a recent (1990) study of medical students, house staff, and junior faculty at one medical school, twice as many female than male house staff and junior faculty reported that

they had never had a mentor.[5] In the sample studied by Levinson and co-workers, minority women were even less likely than their white female colleagues to have the benefit of a mentor.

Because a mentor could be either male or female, the small number of women in senior positions who could serve as mentors theoretically does not preclude more junior women from obtaining mentoring. In truth, the scarcity of high-level academic women as mentors is problematic. First, male faculty may be less likely to develop a mentoring relationship with a female student or junior faculty member than with a male. One motivation for senior faculty of developing a mentoring relationship may be the sense of reproducing oneself. In selecting a protégé, faculty members may, without their own awareness, lean towards selecting persons who are of the same sex and race. The bias toward selecting a protégé who is similar to oneself (beyond a similarity in area of academic interest) works against women and minorities.[6] Further, insofar as male faculty may think that women will be less likely to succeed in academic careers, they may shy away from taking them on as protégés. This can become a self-fulfilling prophecy if women then do not have access to the information and help that a mentor can provide.

These processes are subtle. As Menges and Exum note in reviewing barriers to the advancement of women and minority faculty in academia, "slow progress is less the result of deliberately prejudiced actions than the failure of persons of good will to ensure equity."[7(p139)] Even if the selection of protégés were equal by sex, there would still be a problem for women who had male mentors. While either a man or woman can be a mentor for a woman, only a woman can fully constitute a role model for another woman. As Levinson and associates note, while mentors provide guidance on professional issues, role models provide an example of both professional and personal life.[2] For most women, the example of other women successfully combining a satisfying personal and professional life provides critical information and motivation to aspire to a similar role.

In their study, Levinson and co-workers found a more powerful effect of having a mentor than of having a role model in terms of career success, although both were related to career satisfaction. This finding should be interpreted cautiously. First, as the authors note, the survey was of full-time faculty. A lack of role models may play a particularly strong role in the decision of women not to continue in academic medicine. In addition, the analysis compared women who reported having an ongoing relationship with a role model with those who did not.[2] Effective functioning of role models may or may not require an ongoing relationship. It may be that among those women who reported not having had an ongoing relationship with a role model were women who had previously had a role model who provided them with a positive image of the possibilities of an academic career in medicine. If this is combined with currently having a mentor, a woman may have both the motivation and the practical support necessary to persevere and succeed. In future research, it would be useful to examine the joint and separate functioning of role models and mentors and to consider the question of the nature and timing of influence of each.

Levinson and colleagues discuss possible remedies to the lack of role models and mentors for women in academic medicine.[2] These include encouragement for senior faculty to place a high priority on providing mentoring and encouraging junior women to seek out such relationships and to develop other resources, including peers, to supplement lacks in the mentoring they may receive. Unfortunately, there is reason to think that these measures will fall short of achieving the kind of change that is necessary to improve substantially the situation for women in academic medicine. The processes noted earlier may be subtle but they are nonetheless powerful. It is not enough to encourage senior faculty to mentor. There are already too many good and worthy activities that faculty "should" engage in. True incentives for such activity are needed, including considering mentoring activity as a critical aspect of merit and advancement for senior faculty. In addition, incentives are needed to help junior faculty who might not otherwise be selected as protégés. Further, there is no substitute for having a sufficient number of women in senior positions to serve as role models. To accomplish this, institutional changes are needed that enable and encourage women to stay in academic careers. This involves some change in the academic climate, which has been a "chilly" one for women.[8] Policy changes are needed to make it easier for women as well as men to combine family and career. Recent policies adopted by some medical schools to establish childbearing and family care leave, including procedures for slowing the tenure clock, are examples of policies that will help to keep women in the academic track.

Felice Schwartz has argued in the *Harvard Business Review* that women were moving into a seller's market in the corporate world ("Management Women and the New Facts of Life," January-February 1989, pp 67-76). This change was occurring because institutions were recognizing that "80% of new entrants in the work force over the next decade will be women, minorities, and immigrants" (p 68). These demographics will affect medicine as well. To get the best physicians to teach, do research, and care for patients, medical schools will need to recognize the need for women and the needs of women.

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REFERENCES

1. Whiting BE, Bickel J: Women on faculties of US medical schools, 1978-1989. Acad Med 1990; 65:277-278
2. Levinson W, Kaufman K, Clark B, Tolle SW: Mentors and role models for women in academic medicine. West J Med 1991; 154:423-426
3. Kirsling RA, Kochar MS: Mentors in graduate medical education at the Medical College of Wisconsin. Acad Med 1990; 65:272-273
4. Riley S, Wrench D: Mentoring among women lawyers. J Appl Soc Psychol 1985; 15:374-386
5. Osborn EHS, Ernster V, Martin JB: Women's Attitudes Towards a Career in Academic Medicine: The View from UCSF. Presented at the annual meeting of the Association of American Medical Colleges, October 1990, San Francisco, California
6. Blackwell JE: Mentoring: An action strategy for increasing minority faculty. Academe 1989 Sep-Oct, pp 8-14
7. Menges RJ, Exum WH: Barriers to the progress of women and minority faculty. J Higher Educ 1983; 54:123-144
8. Sandler B: The Campus Climate Revisited: Chilly for Women Faculty, Administrators and Graduate Students—Project on the Status and Education of Women. Washington, DC, Assoc of American Colleges, 1986

Hypoglycemia—A Major Risk of Insulin Therapy

IN THIS ISSUE of the journal, Dr Service describes the pathophysiology, evaluation, and treatment of hypoglycemia.[1] I will focus on one of the most common causes of hypoglycemia: iatrogenic hypoglycemia secondary to insulin treatment of diabetes.

How common is hypoglycemia? Most experienced clini-